

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Washington</u>		7131		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Big Spring</u> (No. <u>8</u> )		St. <u>Ward</u>		Registered No. <u>314</u>	
2 FULL NAME <u>Charles Holland Atkins</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>Dec. 15</u> , 191 <u>3</u> (Month) (Day) (Year)					
7 AGE <u>6</u> yrs. <u>25</u> mos. <u>25</u> ds.		If LESS than 1 day, ... hrs. ... min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>West Virginia</u>					
PARENTS	10 NAME OF FATHER <u>J. H. Atkins</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>West Virginia</u>				
	12 MAIDEN NAME OF MOTHER <u>Martha Pedrick</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>West Virginia</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. H. Atkins</u> (Address) <u>Hedgesville W. Va.</u>					
15 FILED <u>July 11th</u> , 191 <u>4</u> <u>R. J. Hull</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>July 10th</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>July 9th</u> , 191 <u>4</u> , to <u>July 10th</u> , 191 <u>4</u> , that I last saw him alive on <u>July 10th</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>8 P. M.</u> , The CAUSE OF DEATH* was as follows: <u>Whooping Cough</u> (Duration) ... yrs. ... mos. <u>14</u> ds. Contributory (Secondary) <u>Pneumonia</u> (Duration) ... yrs. ... mos. ... ds. (Signed) <u>Jonathan P. Perry</u> , M. D. <u>July 11th</u> , 191 <u>4</u> (Address) <u>Charmington</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds. Where was disease contracted, if not at place of death? Former or usual residence.					
19 PLACE OF BURIAL OR REMOVAL <u>Hedgesville W. Va.</u>				DATE OF BURIAL <u>July 12</u> , 191 <u>4</u>	
20 UNDERTAKER <u>R. A. Jacques</u>				ADDRESS <u>Hedgesville W. Va.</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

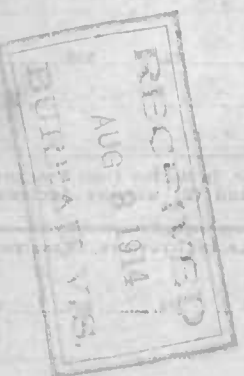
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plasterer*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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AUG 8 1914

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1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Washington</u> 7132			Registered No. <u>309</u>	
Village or City <u>Beaver Creek Pike, Saxton Switch</u> (No. <u>120</u> )			Ward) [It death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>John W. Albin</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)		
6 DATE OF BIRTH <u>Oct. 15, 1842</u> (Month) (Day) (Year)				
7 AGE <u>71</u> yrs. <u>9</u> mos. <u>1</u> ds. <u>1</u> LESS than 1 day, .... hrs. OR .... min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment to which employed (or employer) <u>—</u>				
9 BIRTHPLACE (State or country) <u>Stephen City Va.</u>				
PARENTS	10 NAME OF FATHER <u>Washington Albin</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Frederick Va</u>			
	12 MAIDEN NAME OF MOTHER <u>Mary Ewing</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>do not know</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr. George Holliday</u> <u>Beaver Creek Pike Saxton Switch</u> (Address)				
15 Filed <u>July 21, 1914</u> <u>M. L. Miller</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>July 20, 1914</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY That I attended deceased from <u>June 20, 1914</u> , to <u>July 18, 1914</u> , that I last saw him alive on <u>July 15, 1914</u> , and that death occurred on the date stated above, at <u>4 a</u> m. The CAUSE OF DEATH* was as follows: <u>Chronic Bright</u>				
<u>One month</u> (Duration) yrs. mos. ds.				
Contributory (Secondary) <u>Kidney</u> (Duration) yrs. mos. ds.				
(Signed) <u>Chas. B. Boyle</u> , M. D. <u>July 21, 1914</u> (Address) <u>Hagerstown Md.</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, It not at place of death? Former or usual residence				
19 PLACE OF BURIAL OR REMOVAL <u>Smithsburg Cemetery</u>				DATE OF BURIAL <u>July 22, 1914</u>
20 UNDERTAKER <u>S. Kella Lorman Hagerstown Md.</u>				ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 7133  
 County Washington  
 Village or City Hagerstown (No. Fremont)  
 St. 5th Ward  
 Registration Dist. No. 302  
 [if death occurred in a hospital or institution, give its NAME instead of street and number.]  
 2 FULL NAME Elijah Baker

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH June 25, 1859  
 (Month) (Day) (Year)

7 AGE 55 yrs. 10 mos. 10 ds. 11 LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Laborer  
 (b) General nature of industry, business, or establishment in which employed (or employer) Concrete laying

9 BIRTHPLACE (State or country) Pa.

10 NAME OF FATHER Joseph Baker  
 11 BIRTHPLACE OF FATHER (State or country) U.S.  
 12 MAIDEN NAME OF MOTHER Jane Currens  
 13 BIRTHPLACE OF MOTHER (State or country) U.S.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Baker  
 (Address) Hagerstown Md.

15 Filed 7/6 -, 1914 Henry Davis  
 REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 5, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1, 1913, to July 5, 1914, that I last saw him alive on July 4, 1914

and that death occurred on the date stated above, at 8 P. m.  
 The CAUSE OF DEATH\* was as follows:

puerperal hemorrhage  
 (Duration) 1 yrs. 3 mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.  
 (Signed) J. D. Laughlin, M. D.  
July 6, 1914 (Address) Hagerstown Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Committsburg Md DATE OF BURIAL July 7, 1914  
 20 UNDERTAKER Francis Bros ADDRESS 33 E Wash St



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

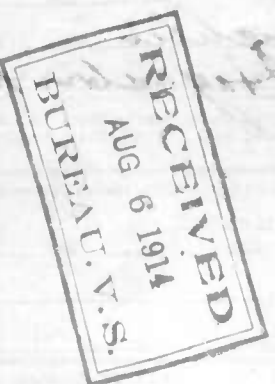
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**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 ds. Never report *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Washington</u>		7134	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hagustown</u> (No. <u>37</u> <u>Bushwa ave</u> St.; <u>2nd</u> Ward)		Registered No. <u>302</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME <u>Still Born</u> <u>Baker</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)		
6 DATE OF BIRTH <u>July 3</u> , 19 <u>14</u> (Month) (Day) (Year)				
7 AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____				
9 BIRTHPLACE (State or country) <u>Hagustown Md</u>				
PARENTS	10 NAME OF FATHER <u>Roy Baker</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Hagustown Md</u>			
	12 MAIDEN NAME OF MOTHER <u>Rosa Roberts</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Ind. Co. Ind</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>James R. Roberts</u> <u>37 Bushwa ave Hagustown Md</u>				
15 Filed <u>7-6-</u> , 19 <u>14</u> <u>Henry Davis</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>July 3</u> , 19 <u>14</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, that I last saw h_____ alive on _____, 19____, and that death occurred on the date stated above, at <u>3 a.</u> m, The CAUSE OF DEATH* was as follows: <u>Still Born</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory (Secondary) _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>E. H. Teicher</u> , M. D. <u>July 3</u> , 19 <u>14</u> (Address) <u>Hagustown Md.</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Bellmore Meth. Co Home</u>				DATE OF BURIAL <u>July</u> , 19 <u>14</u>
20 UNDERTAKER <u>S. K. Lowman Hagustown Md</u>				ADDRESS _____

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**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 7135  
 County Washington (No. 49)  
 State of MARYLAND  
 CERTIFICATE OF DEATH  
 Registered No. 305

Village or City Bonnsboro (No. \_\_\_\_\_) St; \_\_\_\_\_ Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John Henry Bast.

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) married

6 DATE OF BIRTH Jan. 12, 1941  
 (Month) (Day) (Year)

7 AGE 73 yrs. 6 mos. 19 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Elias Bast

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Lambert

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) William F. Bast - Son  
 (Address) Bonnsboro Md

15 July 22, 1941 Geo. M. Stoen  
 Filed \_\_\_\_\_ REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 20<sup>th</sup>, 1941  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 6<sup>th</sup>, 1941, to July 21, 1941.

that I last saw him alive on July 20, 1941.

and that death occurred on the date stated above, at 8 Del. Ave.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Gall Bladder

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 15 ds.

Contributory (Secondary) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) E. J. Smith, M. D.

July 21<sup>st</sup>, 1941 (Address) Bonnsboro Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. in the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Bonnsboro Cemetery DATE OF BURIAL July 23<sup>rd</sup>, 1941

20 UNDERTAKER F. W. Abenderfer ADDRESS Frederick Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

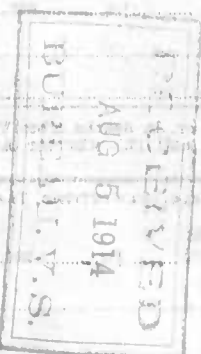
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The unmarried worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not rainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Washington 7136 S.  
Village or Wmport, (No. Church St; Ward)  
FULL NAME Mary Brindle  
Registered No. 301  
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Child  
6 DATE OF BIRTH July 19, 1914  
(Month) (Day) (Year)  
7 AGE Still born If LESS than 1 day, hrs. yrs. mos. ds. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Child  
(b) General nature of industry, business, or establishment in which employed (or employer) Child

9 BIRTHPLACE (State or country) Walthamport Md

10 NAME OF FATHER C F Brindle

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Lizy Kettering

13 BIRTHPLACE OF MOTHER (State or country) Wmport Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) C F Brindle

(Address) Walthamport Md

15 Filed July 20, 1914 by E. C. Richard Local REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 19, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 1914 to 1914

that I last saw him alive on 1914

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

still born  
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Signed) Thos. B. Buss, M. D.  
July 19, 1914 (Address) Wmport Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Walthamport Md DATE OF BURIAL July 20, 1914

20 UNDERTAKER Lewis W. Kups ADDRESS Wmport Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

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**1 PLACE OF DEATH** 7137 ✓ **STATE OF MARYLAND**  
**CERTIFICATE OF DEATH**  
 County Washington **Registration Dist. No.** 302  
 Village or City Hagerstown (No. Wash. Co. Hospital St.; 3rd Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]  
**2 FULL NAME** Otho Chauncy.

## PERSONAL AND STATISTICAL PARTICULARS

**3 SEX** male **4 COLOR OR RACE** white **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** divorced  
 (Write the word)

**6 DATE OF BIRTH** Don't Know, 1\_\_\_\_  
 (Month) (Day) (Year)

**7 AGE** about 60 yrs. \_\_\_\_ mos. \_\_\_\_ ds. **OR** 1 day \_\_\_\_ hrs. \_\_\_\_ min. ?  
 If LESS than 1 day, \_\_\_\_ hrs. \_\_\_\_ min. ?

**8 OCCUPATION**  
 (a) Trade, profession, or particular kind of work Laborer  
 (b) General nature of industry, business, or establishment in which employed (or employer) "

**9 BIRTHPLACE** (State or country) Maryland.

**10 NAME OF FATHER** Wm Chauncy.

**11 BIRTHPLACE OF FATHER** (State or country) Md.

**12 MAIDEN NAME OF MOTHER** Unknown

**13 BIRTHPLACE OF MOTHER** (State or country) "

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) M. F. Sibert

(Address) Hagerstown, Md.

**15** Filed 7/10-, 1914 Henry Davis  
 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH** July 9th, 1914  
 (Month) (Day) (Year)

**17 I HEREBY CERTIFY, That** I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_

and that death occurred on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH\* was as follows:

Fractured Skull by  
falling at Library  
July 8th 1914  
 (Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

**Contributory** Fractured Skull  
**Secondary**

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) John Autenry J.P., M.D.  
July 9, 1914 (Address) Hagerstown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

**19 PLACE OF BURIAL OR REMOVAL** Blair Valley **DATE OF BURIAL** 7/11, 1914

**20 UNDERTAKER** C. M. Suter & Son Hagerstown Md. **ADDRESS**



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

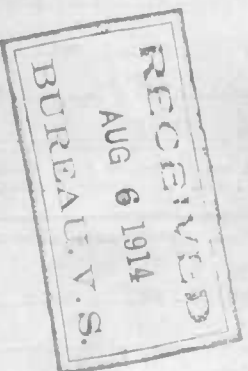
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH Washington 7138  
 County Franklin (No. 43)  
 Village or City Franklin (No. 43) St. Franklin Ward Franklin  
 2 FULL NAME Byron A. Smith Baggett  
 Registration Dist. No. 309  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
 (Write the word)

6 DATE OF BIRTH Jan 10, 1878  
 (Month) (Day) (Year)

7 AGE 39 5 13 If LESS than 1 day, hrs. 1 day, hrs. 1 day, hrs. 1 day, hrs.  
 yrs. mos. ds. OR min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work Horse Fife  
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Boonsboro Md.

10 NAME OF FATHER Frank Smith

11 BIRTHPLACE OF FATHER (State or country) Boonsboro Md.

12 MAIDEN NAME OF MOTHER Catherine Morrison

13 BIRTHPLACE OF MOTHER (State or country) Boonsboro Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Byron A. Baggett

(Address) Franklin, Md.

15 Filed July 25, 1914 M. S. Miller

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 24, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1914, to 7/24, 1914, that I last saw her alive on 7/24, 1914

and that death occurred on the date stated above, at 10 a. m.

The CAUSE OF DEATH\* was as follows:

Carcinoma of Breast  
metastasis to Cervix + Ovary  
 (Duration) 2 yrs. mos. ds.

Contributory ☒ Secondary

(Signed) V. S. D. Miller, M. D.  
July 24, 1914 (Address) Franklin, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 7 yrs. 2 mos. 4 ds. In the State 7 yrs. 2 mos. 4 ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Franklin DATE OF BURIAL July 25, 1914

20 UNDERTAKER L. F. Keech ADDRESS Franklin

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*" etc. State cause for every surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH **7139**  
County Wash,

Village or City Hyphur (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

2 FULL NAME Esther Elizabeth Levine

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 313

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) X  
6 DATE OF BIRTH July 28, 1913  
(Month) (Day) (Year)  
7 AGE 11 yrs. 25 mos. 5 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ mo. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work None  
(b) General nature of industry, business, or establishment in which employed (or employer)  
9 BIRTHPLACE (State or country) Wash Co Md.

PARENTS  
10 NAME OF FATHER James Walter Clutz  
11 BIRTHPLACE OF FATHER (State or country) Franklin Dc  
12 MAIDEN NAME OF MOTHER Katherine Elj Kope  
13 BIRTHPLACE OF MOTHER (State or country) Illinois

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant Harriet Rome  
(Address) Hyphur Md

15 Filed July 1914  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 25, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1914, to July 25, 1914

that I last saw her alive on July 23, 1914

and that death occurred on the date stated above, at 60 m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis ?

Contributory (Secondary) Tuberculosis, meningitis  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Glenn M. Smith, M.D.  
July 25, 1914 (Address) Blair Rd, Hyphur  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mount Airy Pa DATE OF BURIAL July 28, 1914

20 UNDERTAKER E. J. Jones ADDRESS Hyphur Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Scalle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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AUG 3

1914



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1 PLACE OF DEATH  
County Washington (No. 1)  
Village or City Bakersville (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)  
2 FULL NAME Anna Virginia Cook

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Registration Dist. No. 311

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Aug. 20, 1880  
(Month) (Day) (Year)

7 AGE 33 yrs. 10 mos. 25 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John W. Vickers

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Barbara C. Hammond

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W. Vickne

(Address) Bakersville Md

15 Filed July 16, 1914 b. M. Richard  
Local REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 311

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 15, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 6/12, 1914, to 7/15, 1914,

that I last saw her alive on 7/15, 1914

and that death occurred on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH\* was as follows:

Typhoid Fever with  
intestinal hemorrhage

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) S. Russell Gardner, M. D.  
7/16, 1914 (Address) Sharpsburg Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Sharpsburg Md. DATE OF BURIAL July 17, 1914

20 UNDERTAKER Albert Leaf ADDRESS Sharpsburg Md.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

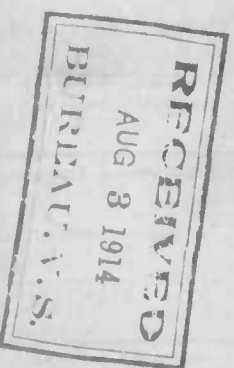
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Garcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Jaundition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **Washington**  
County **Washington**

Village or City **Near Munroe** (No. **151**)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. **305**

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME **Paul Edward Davis**

PERSONAL AND STATISTICAL PARTICULARS

3 SEX **male** 4 COLOR OR RACE **white** 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) **single**

6 DATE OF BIRTH **July 30, 1914**  
(Month) (Day) (Year)

7 AGE **—** yrs. **—** mos. **—** ds. If LESS than 1 day, **—** hrs. **30** min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) **md.**

10 NAME OF FATHER **Harvey B. Davis**

11 BIRTHPLACE OF FATHER (State or country) **md.**

12 MAIDEN NAME OF MOTHER **Hertie B. Gruber**

13 BIRTHPLACE OF MOTHER (State or country) **md.**

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Harvey C. Davis**

(Address) **Keedysville, Md.**

15 **July 30, 1914** **Geo. W. Storr, J.P.**

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **July 30, 1914**  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **July 30, 1914**, to **July 30, 1914**.

that I last saw him alive on **July 30, 1914**

and that death occurred on the date stated above, at **3 a.** m.

The CAUSE OF DEATH\* was as follows:

**Congenital Debility**

(Duration) yrs. mos. ds.  
Contributory **Premature**  
Secondary **Birth**

(Duration) yrs. mos. ds.

(Signed) **V.M. Reichard**, M. D.

**July 30, 1914** (Address) **Fair Play, Md.**

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL **Major Cemetery** DATE OF BURIAL **July 30, 1914**

20 UNDERTAKER **John Clark** ADDRESS **Bowling, Md.**

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*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, STIGMAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Washington</u>		7142 ✓	154	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hagerstown</u> (No. <u>5-7 1/2</u> St. <u>H. Church</u> Ward)		Registration Dist. No. <u>302</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>William Henry Dorsey</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>male</u>	4 COLOR OR RACE <u>colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)			
6 DATE OF BIRTH <u>August 1</u> , 19 <u>42</u> (Month) (Day) (Year)					
7 AGE <u>71</u> yrs. <u>11</u> mos. <u>11</u> ds. OR <u>1</u> day.....hrs. <u>11</u> min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Labourer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>John Dorsey</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>Rachael Jackson</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Henry Stewart</u> (Address) <u>Hagerstown, Md</u>					
15 FILED <u>7/14</u> , 19 <u>44</u> <u>Henry Stewart</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>July 12</u> , 19 <u>44</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, that I attended deceased from <u>July 5</u> , 19 <u>44</u> , to <u>July 12</u> , 19 <u>44</u> , that I last saw him alive on <u>July 6</u> , 19 <u>44</u> , and that death occurred on the date stated above, at <u>1030 A.M.</u> The CAUSE OF DEATH* was as follows: <u>Stroke, probably</u>					
(Duration) <u>3</u> yrs. <u>3</u> mos. <u>—</u> ds. Contributory <u>Cardiac weakness</u> Secondary					
(Signed) <u>A. B. Wilson</u> , M. D. <u>July 14</u> , 19 <u>44</u> . (Address) <u>Hagerstown</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u>—</u>					
19 PLACE OF BURIAL OR REMOVAL <u>Beaver Creek, Maryland</u> DATE OF BURIAL <u>July 14</u> , 19 <u>44</u>					
20 UNDERTAKER <u>A. K. Coffman</u> ADDRESS <u>Hagerstown</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

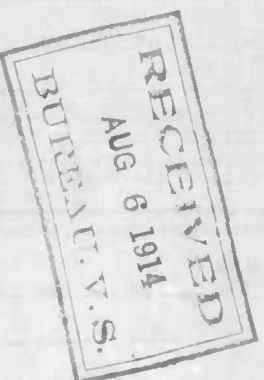
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—Homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

7143

County

Washington

Village or City

Wilson

(No.

District No 23 St.;

Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 303

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Daniel E Drury

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED  
(Write the word)

Widower

6 DATE OF BIRTH

Jul

12

1884

(Month)

(Day)

(Year)

7 AGE

61

yrs

—

mos

16

ds

If LESS than  
1 day.....hrs.  
OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Pennsylvania

PARENTS

10 NAME OF FATHER

Ignatius Drury

11 BIRTHPLACE OF FATHER  
(State or country)

German

12 MAIDEN NAME OF MOTHER

No Record of

13 BIRTHPLACE OF MOTHER  
(State or country)

German

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Melhard Kretzer

(Address)

Wilson Md

15

Filed

July 30<sup>th</sup> 1914

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July

28<sup>th</sup>

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

April 6<sup>th</sup>

1914

to

July 28<sup>th</sup>

1914

that I last saw him alive on

July 27<sup>th</sup>

1914

and that death occurred on the date stated above, at

7 P. m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis of the Lungs and Peritonitis

(Duration) 2 yrs. — mos. — ds.

Contributory  
Secondary

(Duration) — yrs. — mos. — ds.

(Signed)

Jonathan P. Perry, M. D.

July 28<sup>th</sup>

1914

(Address)

Chesapeake

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. — mos. — ds.

In the

State

yrs. — mos. — ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wilmington Pa

July 31<sup>st</sup> 1914

20 UNDERTAKER

ADDRESS

A. L. Hoffman

Hagerstown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

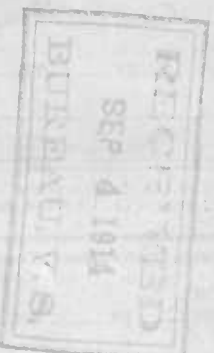
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Fireman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

County Washington 7144Village or City Indian Springs (No. 189)STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 314

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Fannie Ebersole

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH 7 15 1828  
(Month) (Day) (Year)

7 AGE 85 yrs. 6 mos. 28 ds. 8 If LESS than 1 day, hrs. OR min. ?

9 OCCUPATION (a) Trade, profession, or particular kind of work Retired (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Penn.

10 NAME OF FATHER John Hersh

11 BIRTHPLACE OF FATHER (State or country) Penn.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Albert Ebersole(Address) Indian Springs

15 Filed July 16, 1914 H. B. Hill

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 15, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_.

that I last saw him alive on \_\_\_\_\_, 191\_\_\_\_.

and that death occurred on the date stated above, at 10 A. m.

The CAUSE OF DEATH\* was as follows:

Sudden Heart Failure(Duration) Unknown yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jonathan P. Perry, M. D.July 15th, 1914 (Address) Clearspring

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the 12 State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence:

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Winnetta CemeteryJuly 17, 1914

20 UNDERTAKER

ADDRESS

L. P. SydnorClearspring

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

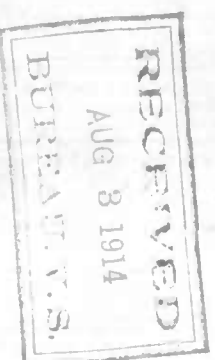
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Gastric" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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AUG 3 1914





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1 PLACE OF DEATH 7145  
County Washington

Village or City Smithsburg (No. \_\_\_\_\_, St. \_\_\_\_\_ Ward \_\_\_\_\_)

2 FULL NAME Adeline Kaufman Fekl.

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 306

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH February 24th, 1849  
(Month) (Day) (Year)

7 AGE 65 yrs. 4 mos. 28 ds. If LESS than 1 day \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Pennsylvania

10 NAME OF FATHER Jacob Bonner

11 BIRTHPLACE OF FATHER (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Anna Kaufman

13 BIRTHPLACE OF MOTHER (State or country) Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant William C. Fekl.

(Address) Smithsburg, Pa.

15 Filed July 23, 1914 J. H. Ferguson  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 22nd, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 13th, 1914, to July 22nd, 1914, that I last saw him alive on July 22nd, 1914.

and that death occurred on the date stated above, at 9-30 P. m.

The CAUSE OF DEATH\* was as follows:

Paralysis

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 10 ds.

Contributory (Secondary) \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Joseph Protzman, M. D.  
July 23, 1914 (Address) Smithsburg, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Smithsburg, Md. DATE OF BURIAL July 25th, 1914

20 UNDERTAKER Geo. B. Hoover ADDRESS Smithsburg

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 7  
County WASHINGTON

Village or City HAGERSTOWN (No. W.M.R.R. YARDS)

**2** **FULL NAME**.....GEORGE EDGAR FEIGLEY

### PERSONAL AND STATISTICAL PARTICULARS

3 SEX  MALE	4 COLOR OR RACE  WHITE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write in detail)  MARRIED.
-------------------	------------------------------	---

9 DATE OF BIRTH SEPTEMBER 15, 1880.  
(Month) (Day) (Year)

7 AGE 33 yrs 9 mos 17 ds. It LESS than  
1 day.....hrs.  
OR.....min.?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work R. R. BRAKEMAN  
(b) General nature of industry, business, or establishment in which employed (or employer) RR RR RR RR RR RR RR RR RR RR

9 BIRTHPLACE  
(State or country)  
MARYLAND.

PARENTS	10 NAME OF FATHER	JAMES FEIGLEY
	11 BIRTHPLACE OF FATHER (State or country)	MARYLAND.
	12 MAIDEN NAME OF MOTHER	LOUISA FISHER
	13 BIRTHPLACE OF MOTHER (State or country)	MARYLAND.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) MRS. GEORGE FEIGLEY

(Address).....EUTAW STREET.....

16  
Filed 7/3- 1914 Henry Davis  
REGISTRAR

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 502

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 2, 1944  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
July 2, 1914, to July 2, 1914,  
that I last saw him alive on July 2, 1914

and that death occurred on the date stated above, at 12, 500 m.  
The CAUSE OF DEATH\* was as follows:

Contributor Death occurred in 12 hrs.

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ da.  
(Signed) J. P. Laughlin, M. D.  
July 13, 1914 (Address) Hogestown Ind

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
if not at place of death? \_\_\_\_\_  
Former or  
usual residence. \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
ROSE HILL CEMETERY	JULY 5 <sup>th</sup> 1914

20 UNDERTAKER	ADDRESS
C. M. SUTER & SON	HAGERSTOWN

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MD.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 7147  
 County Washington  
 Village or City Hayestown (No. 5-26 Howard St.; Ward)  
 2 FULL NAME Unmarried Child Gossard  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single  
 6 DATE OF BIRTH July 19, 1914  
 (Month) (Day) (Year)  
 7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Robert I Gossard  
 11 BIRTHPLACE OF FATHER (State or country) Pennsylvania  
 12 MAIDEN NAME OF MOTHER Ethel A Batt  
 13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles E Batt  
 (Address) Hayestown Md.

15 Filed 7/20, 1914 Henry Davis  
 REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7, 19, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1914, to July 19, 1914,  
 that I last saw him alive on July 19, 1914

and that death occurred on the date stated above, at 10 a.m.  
 The CAUSE OF DEATH\* was as follows:

Prémature birth at  
4 mos. (Duration) yrs. mos. ds.

Contributory Prémature  
 Secondary (Duration) yrs. mos. ds.

(Signed) Robert I Gossard, M. D.  
7/19, 1914 (Address) Hayestown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hayestown Md July 19, 1914

20 UNDERTAKER ADDRESS  
H. G. Gossard Hayestown Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

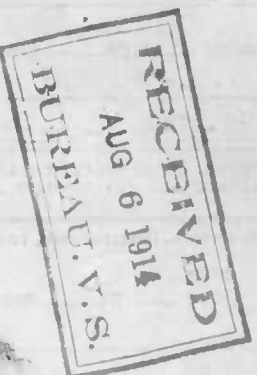
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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(Internment legal,  
see letter in file)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Washington</u> 7148		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hagerstown</u> (No. <u>113</u> )		Registration Dist. No. <u>302</u>	
2 FULL NAME <u>Emerson Amer Hager</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>	
6 DATE OF BIRTH <u>May 28</u> , 18 <u>76</u> (Month) (Day) (Year)			
7 AGE <u>38</u> yrs. <u>1</u> mos. <u>2</u> ds.		If LESS than 1 day.....hrs. OR.....min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>See Merchant</u> (b) General nature of Industry, business, or establishment in which employed (or employer) <u>Hag Ice Co</u>			
9 BIRTHPLACE (State or country) <u>Md</u>			
PARENTS	10 NAME OF FATHER <u>J. Garvin Hager</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u> <u>Malott</u>		
	12 MAIDEN NAME OF MOTHER <u>Mollie Malotte</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. E. A. Hager</u> (Address) <u>Hagerstown Md</u>			
15 Filed <u>7/2</u> , 191 <u>4</u> <u>Henry Davis</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>July 1st</u> , 191 <u>4</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>April 2</u> , 191 <u>4</u> to <u>July 1st</u> , 191 <u>4</u> that I last saw him alive on <u>July 1st</u> , 191 <u>4</u> and that death occurred on the date stated above, at <u>4:30 P.m.</u> The CAUSE OF DEATH* was as follows: <u>Hepatic Sclerosis</u> (Duration) <u>3</u> yrs. <u>—</u> mos. <u>—</u> ds. Contributory <u>Renal Sclerosis</u> Secondary (Duration) <u>3</u> mos. <u>—</u> ds. (Signed) <u>C. P. Scheller</u> , M. D. <u>July 2th</u> , 191 <u>4</u> (Address) <u>Hagerstown</u>			
State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death..... yrs. .... mos. .... ds. In the State..... yrs. .... mos. .... ds. Where was disease contracted, If not at place of death? Former or usual residence.			
19 PLACE OF BURIAL OR REMOVAL <u>Rose Hill</u>		DATE OF BURIAL <u>7/4</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Natkins &amp; Minnich Hag, Md.</u>		ADDRESS	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

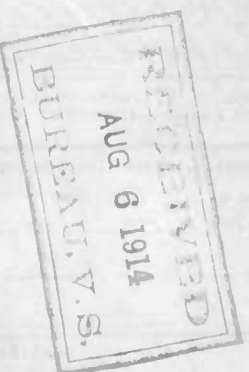
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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

7149

County

Washington

Village or City

Agarstown (No. Washington Hospital St. 3 Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Myra Harshman

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)

married

6 DATE OF BIRTH

Jan 11, 1882  
(Month) (Day) (Year)

7 AGE

32 yrs. 6 mos. 6 ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Lewis Lawrence

11 BIRTHPLACE OF FATHER

(State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Anna Agurman

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Shirley Harshman

(Address)

Sharpsburg, Md.

15

Filed

7/17, 1914 Henry Davis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 17, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

June 14, 1914 to July 17, 1914

that I last saw her alive on July 16, 1914

and that death occurred on the date stated above, at 1 a. m.

The CAUSE OF DEATH\* was as follows:

Septic Erythraemia

Contributory  
Secondary(Duration) yrs. mos. ds.  
Typhoid Fever

(Signed)

D. M. Richard, M. D.

July 17, 1914 (Address) Fair Play

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Major Cemetery July 19, 1914

20 UNDERTAKER

ADDRESS

N. C. Richard Fair Play, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Insultion," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or misarrriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH . 7150  
County Washington  
Village or City Hanover (No. \_\_\_\_\_, St.; \_\_\_\_\_ Ward)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 304

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Barnes Bliss

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Dec 30, 1842  
(Month) (Day) (Year)

7 AGE 71 yrs. 7 mos. 9 ds. It LESS than 1 day, \_\_\_\_ hrs. \_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Barnes  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Penn. Co. Pa.

10 NAME OF FATHER Samuel Bliss  
11 BIRTHPLACE OF FATHER (State or country) Penn.  
12 MAIDEN NAME OF MOTHER Sallie E. Bliss  
13 BIRTHPLACE OF MOTHER (State or country) Penn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John T. Bliss  
(Address) 7150 P. St. N. W.

15 Filed Jan 10, 1914 P. J. M. Bliss  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 8, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1914, to July 5, 1914.

that I last saw him alive on July 5, 1914.

and that death occurred on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Valvular Heart disease  
Heart Failure  
(Duration) 2 yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) W. S. Gray, M. D.  
7/9, 1914. (Address) Hanover Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL St. James Church DATE OF BURIAL July 10, 1914

20 UNDERTAKER Dan M. M. M. ADDRESS Hanover Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

7151

County WashingtonSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 307Village or City Hagerstown (No. 645 North Mulberry St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Nellie Iona Huyett

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, single WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

Feb. 28, 1912  
(Month) (Day) (Year)

7 AGE

2 yrs. 4 mos. 22 ds. 1 day.....hrs. OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Frank T. Huyett

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Sadie C. Miner

13 BIRTHPLACE OF MOTHER (State or country)

Pennsylvania

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Sadie C. Huyett,(Address) 208 Fair Ground Ave.

15

Filed 7/21-, 1914H. Henry Davis  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 20, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

July 20, 1914, to July 20, 1914,  
that I last saw h. at alive on July 20, 1914and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

Third Degree Burn involving 3rd entire body.  
(Duration) yrs. 3 mos. 3 hrs.

Contributory Secondary

Playing with matches and igniter  
(Duration) yrs. 3 mos. 3 hrs.(Signed) M. T. Bryder, M. D.July 20, 1914 (Address) Hagerstown, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Hagerstown, Md.

DATE OF BURIAL

July 21, 1914

20 UNDERTAKER

H. Coffman

ADDRESS

Hagerstown, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

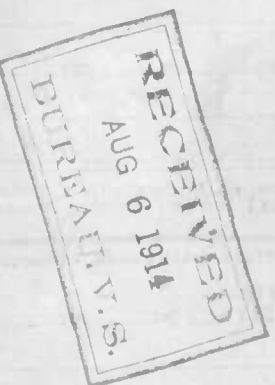
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Washington</u>		7152	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Dargon</u> (No. ....)		St.; .....		Registered No. <u>310</u>
2 FULL NAME <u>Ingram</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Boy</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)		
6 DATE OF BIRTH <u>July 25, 1914</u> (Month) (Day) (Year)		7 AGE ..... yrs. .... mos. .... ds. OR LESS than 1 day, .... hrs. OR .... min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <u>Ind.</u>				
PARENTS	10 NAME OF FATHER <u>Robert Ingram</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Ind.</u>			
	12 MAIDEN NAME OF MOTHER <u>Cora Reynolds</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Ind.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Robert Ingram</u> (Address) <u>Hayes Ferry, Ind.</u>				
15 Filed <u>July 25, 1914</u> <u>W. G. Houskins</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>July 25, 1914</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191..... that I last saw h..... alive on ..... 191..... and that death occurred on the date stated above, at ..... m. The CAUSE OF DEATH* was as follows: <u>Still Born</u> (Duration) ..... yrs. .... mos. .... ds. Contributory (Secondary) ..... (Duration) ..... yrs. .... mos. .... ds. (Signed) <u>J. P. Hodges</u> , M. D. <u>July 25, 1914</u> (Address) <u>Hayes Ferry, Ind.</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds. Where was disease contracted, If not at place of death? Former or usual residence.....				
19 PLACE OF BURIAL OR REMOVAL <u>Ample Manor</u>		DATE OF BURIAL <u>July 25th, 1914</u>		
20 UNDERTAKER <u>John McKeeth</u>		ADDRESS <u>Bellevue, Ind.</u>		



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

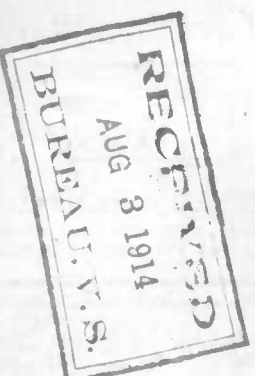
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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AUG 3 1914

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Washington</u>		7153	159	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hagerstown</u> No. <u>531</u> <u>N. Locust</u> St.; _____ Ward		Registration Dist. No. <u>302</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Bernard Carlton Kline</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Infant.</u> (Write the word)			
6 DATE OF BIRTH <u>July</u> <u>19</u> , 191 <u>4</u> (Month) (Day) (Year)					
7 AGE _____ yrs. _____ mos. <u>2</u> ds. It LESS than 1 day. _____ hrs. OR _____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work _____ (b) General nature of industry, business, or establishment in which employed (or employer) _____					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>W. Guy Kline</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>Hora May Rouzgar</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Ohio</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>W. Guy Kline</u> (Address) <u>Maryland</u>					
15 Filed <u>7/21</u> , 191 <u>4</u> <u>Henry Davis</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>July</u> <u>21</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>July 19</u> , 191 <u>4</u> , to <u>July 21</u> , 191 <u>4</u> , that I last saw him alive on <u>July 20</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>2:45</u> p.m. The CAUSE OF DEATH* was as follows: <u>Failure of the heart to close</u>					
(Duration) _____ yrs. _____ mos. _____ ds.					
Contributory Secondary <u>Heart Disease</u>					
(Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>Ernest S. Everett</u> , M. D. <u>July 21</u> , 191 <u>4</u> (Address) <u>27 W. Foundation St</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Frederick, Maryland</u> DATE OF BURIAL <u>July 21</u> , 191 <u>4</u>					
20 UNDERTAKER <u>A. K. Copman</u> ADDRESS <u>Hagerstown</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**1 PLACE OF DEATH** 7154  
 County Washington  
 Village or City Hagerstown (No. 15) E. North St. 4th Ward  
**2 FULL NAME** William H. Landis  
 Registration Dist. No. 302  
 [It death occurred in a hospital or institution, give its NAME instead of street and number.]

**PERSONAL AND STATISTICAL PARTICULARS**  
**3 SEX** male  
**4 COLOR OR RACE** white  
**5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** married  
 (Write the word)

**6 DATE OF BIRTH** Dec 18, 1840  
 (Month) (Day) (Year)

**7 AGE** 73 yrs. 7 mos. - ds. It LESS than 1 day, \_\_\_\_ hrs. OR \_\_\_\_ min. ?

**8 OCCUPATION**  
 (a) Trade, profession, or particular kind of work. farmer  
 (b) General nature of Industry, business, or establishment in which employed (or employer) \_\_\_\_\_

**9 BIRTHPLACE** (State or country) Maryland

**10 NAME OF FATHER** Henry Landis

**11 BIRTHPLACE OF FATHER** (State or country) Maryland

**12 MAIDEN NAME OF MOTHER** Lavinia Middlekauff

**13 BIRTHPLACE OF MOTHER** (State or country) Maryland

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Ray Coffman

(Address) Hagerstown, Md

**15** Filed 7/20, 1914 Henry Davis  
 REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**  
**16 DATE OF DEATH** July 28, 1914  
 (Month) (Day) (Year)

**17 I HEREBY CERTIFY**, that I attended deceased from June 13, 1914, to July 18, 1914, that I last saw him alive on July 17, 1914.

and that death occurred on the date stated above, at 1 a.m.

The CAUSE OF DEATH\* was as follows:

Senility

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

(Signed) Wm. Preston Miller, M. D.

July 18, 1914 (Address) Hagerstown, Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. to the State \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted, It not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

**19 PLACE OF BURIAL OR REMOVAL** Beaver Creek, Md

**DATE OF BURIAL** July 20, 1914

**20 UNDERTAKER** A. R. Coffman

**ADDRESS** Hagerstown, Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Washington</u>		7155		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hagerstown</u> (No. <u>Bellview Ave</u> )		Ward		Registration Dist. No. <u>302</u>	
2 FULL NAME <u>John F. La Vautier</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)			
6 DATE OF BIRTH <u>July 15</u> , 18 <u>89</u> (Month) (Day) (Year)					
7 AGE <u>25</u> yrs. — mos. <u>2</u> ds.		If LESS than 1 day.....hrs. OR.....min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Fireman</u> (b) General nature of Industry, business, or establishment in which employed (or employer) <u>✓</u>					
9 BIRTHPLACE (State or country) <u>Pennsylvania</u>					
PARENTS	10 NAME OF FATHER <u>John R. La Vautier</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Pennsylvania</u>				
	12 MAIDEN NAME OF MOTHER <u>Malissa Atch</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Pennsylvania</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs John F. La Vautier</u> (Address) <u>Hagerstown, Md</u>					
15 Filed <u>7/18</u> , 191 <u>4</u> <u>Henry Davis</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>July 17</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>11 a</u> m. to <u>11 a</u> m. that I last saw him alive <u>about 3 months since</u> , 191 <u>4</u> and that death occurred on the date stated above, at <u>11 a</u> m. The CAUSE OF DEATH was as follows: <u>Gun shot wound of left heart - was suicide</u> (Duration) .....yrs. ....mos. ....ds. Contributory <u>None</u> Secondary ..... (Duration) .....yrs. ....mos. ....ds. (Signed) <u>W. H. Tishier</u> , M. D. <u>July 18</u> , 191 <u>4</u> (Address) <u>Hagerstown Md</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds. Where was disease contracted, If not at place of death? Former or usual residence.....					
19 PLACE OF BURIAL OR REMOVAL <u>Harrisburg Pa</u> DATE OF BURIAL <u>July 20</u> , 191 <u>4</u>					
20 UNDERTAKER <u>A. R. Coffman</u> ADDRESS <u>Hagerstown</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

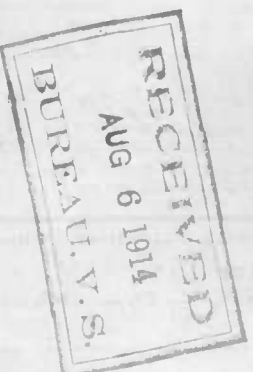
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County WashingtonVillage or City Rayestown(No. Washington St. Hospital Ward)

## 2 FULL NAME

Estlla LucasSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caucasian

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Single

6 DATE OF BIRTH

July 20, 1887  
(Month) (Day) (Year)

7 AGE

27 yrs. 1 mos. 2 ds. OR 1 day, 1 hrs. 2 min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

House work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Washington D.C.

PARENTS

10 NAME OF FATHER

Daniel Neal

11 BIRTHPLACE OF FATHER

(State or country)

Norfolk

12 MAIDEN NAME OF MOTHER

Minnie Jackson

13 BIRTHPLACE OF MOTHER

(State or country)

Washington D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Albert L. Neal

(Address)

Washington D.C.

15

Filed

7/24, 1914

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 22, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 1, 1914 to July 22, 1914that I last saw him alive on July 22, 1914and that death occurred on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH\* was as follows:

Peritonitis(Duration) 22 yrs. 22 mos. 22 ds.Contributory  
SecondaryUnknown(Duration) 22 yrs. 22 mos. 22 ds.

(Signed)

J. R. Laughlin, M. D.  
July 22, 1914 (Address) Rayestown Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 27 yrs. 1 mos. 2 ds. In the State 27 yrs. 1 mos. 2 ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

RayestownJuly 24, 1914

20 UNDERTAKER

ADDRESS

A. L. L. L.Rayestown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

mel

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

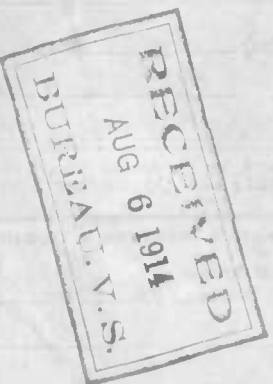
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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<sup>1</sup> PLACE OF DEATH 7157 ✓ S.  
County Washington  
Village or City Kennett (No. 217, Summer St.; 2<sup>nd</sup> Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]  
<sup>2</sup> FULL NAME Unnamed child of A.E. & Annie M. McCarty

## PERSONAL AND STATISTICAL PARTICULARS

<sup>3</sup> SEX male <sup>4</sup> COLOR OR RACE white <sup>5</sup> SINGLE, MARRIED, WIDOWED, OR DIVORCED single (Write the word)  
<sup>6</sup> DATE OF BIRTH July 21, 1914 (Month) (Day) (Year)  
<sup>7</sup> AGE still born If LESS than 1 day.....hrs. yrs.....mos.....ds. OR.....min. ?  
<sup>8</sup> OCCUPATION (a) Trade, profession, or particular kind of work \_\_\_\_\_ (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

<sup>9</sup> BIRTHPLACE (State or country) md.

**PARENTS**  
<sup>10</sup> NAME OF FATHER Andrew E. McCarty  
<sup>11</sup> BIRTHPLACE OF FATHER (State or country) W. Va.  
<sup>12</sup> MAIDEN NAME OF MOTHER Annie Craue  
<sup>13</sup> BIRTHPLACE OF MOTHER (State or country) W. Va.

<sup>14</sup> THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A.E. McCarty  
(Address) 217 Summer St.

<sup>15</sup> Filed 7/21-1914 Henry Davis REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302

## MEDICAL CERTIFICATE OF DEATH

<sup>16</sup> DATE OF DEATH 7-21, 1914  
(Month) (Day) (Year)

<sup>17</sup> I HEREBY CERTIFY, That I attended deceased from July 21, 1914, to July 21, 1914.

that I last saw him alive on \_\_\_\_\_, 191\_\_\_\_

and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH\* was as follows:

Still Born

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Signed) from M. Huber, M. D.  
July 21, 1914 (Address) at Kennett

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

<sup>18</sup> LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

<sup>19</sup> PLACE OF BURIAL OR REMOVAL Cherry Run W. Va. DATE OF BURIAL 7/22, 1914

<sup>20</sup> UNDERTAKER Wm. Suter & Son ADDRESS Kennett md.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

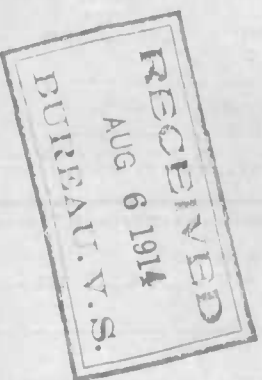
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary, 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 7158 81 STATE OF MARYLAND  
 County Washington CERTIFICATE OF DEATH  
 Registration Dist. No. 302  
 Village or City Hagerstown (No. Hospital St. 7<sup>th</sup> Ward) [If death occurred in a hospital or institution, give its NAME instead of street and number.]  
 2 FULL NAME Henry S. Miller

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower  
 (Write the word)

6 DATE OF BIRTH Sept 14, 1888  
 (Month) (Day) (Year)

7 AGE 75 yrs. 9 mos. 27 ds. OR 1 day, 1 hrs. 1 min. ?  
 It LESS than 1 day, hrs. min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work Farmer Retired  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Maryland

PARENTS  
 10 NAME OF FATHER Jacob Miller  
 11 BIRTHPLACE OF FATHER (State or country) Maryland  
 12 MAIDEN NAME OF MOTHER Fannie Survelly  
 13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David Hill

(Address) Hagerstown Md

15 Filed 7-15-14 Henry Davis  
 REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 14, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1914 to July 14, 1914

that I last saw him alive on July 14, 1914

and that death occurred on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH\* was as follows:

Arteriosclerosis

(Duration) 2 yrs. 10 mos. 18 ds.

Contributory Aspirin and Cordis  
 Secondary Aspirin

(Signed) H. C. Dodge M. D.

July 15, 1914 (Address) Hagerstown

\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hagerstown Md July 16, 1914

20 UNDERTAKER ADDRESS

H. C. Dodge Hagerstown

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Washington</u>		7159		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hagerstown</u> (No. <u>Bellview Asylum St.</u> Ward)		Registration Dist. No. <u>302</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Melchor Mackley</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>4<sup>th</sup></u> <u>Month</u> <u>1894</u> (Day) (Year)					
7 AGE <u>40</u> yrs. <u>0</u> mos. <u>0</u> ds. OR <u>1</u> day <u>0</u> hrs. <u>0</u> min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>1</u> <u>1</u>					
9 BIRTHPLACE (State or country) <u>Md</u>					
PARENTS					
10 NAME OF FATHER <u>Deborah Mackley</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>					
12 MAIDEN NAME OF MOTHER <u>Mary Grimm</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Leila Hopewell</u> (Address) <u>Hagerstown, Md</u>					
15 Filed <u>7/29</u> , 191 <u>4</u> <u>Henny Davis</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>7</u> <u>29</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>April 1</u> , 191 <u>4</u> , to <u>July 29</u> , 191 <u>4</u> , that I last saw him alive on <u>July 27</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>3-0</u> m. The CAUSE OF DEATH* was as follows: <u>Broken compensation of heart.</u>					
(Duration) <u>2</u> yrs. <u>0</u> mos. <u>0</u> ds.					
Contributory Secondary <u>Chronic nephritis</u>					
(Duration) <u>1</u> yrs. <u>0</u> mos. <u>0</u> ds.					
(Signed) <u>F. M. Hoffmeyer</u> , M. D. <u>July 29</u> , 191 <u>4</u> (Address) <u>Hagerstown, Md.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, If not at place of death? Former or usual residence.					
19 PLACE OF BURIAL OR REMOVAL <u>Hall Way Cemetery</u> DATE OF BURIAL <u>July 31</u> , 191 <u>4</u>					
20 UNDERTAKER <u>Watkins &amp; Minnick</u> ADDRESS <u>Hagerstown</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

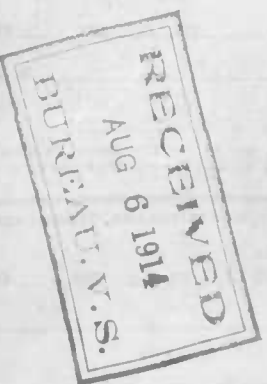
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 7160  
 County Washington (79)  
 Village or City Hagerstown (No. 412, George St St.; 5 Ward)  
 Registration Dist. No. 302  
 2 FULL NAME John S. Mullenix  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Widower  
 6 DATE OF BIRTH 3-3-1841  
 (Month) (Day) (Year)  
 7 AGE 73 yrs. 4 mos. 18 ds. If LESS than 1 day.....hrs. OR.....min. ?  
 8 OCCUPATION  
 (a) Trade, profession, or particular kind of work Engineer  
 (b) General nature of Industry, business, or establishment in which employed (or employer) Locomotive Engineer  
 9 BIRTHPLACE (State or country) Pa

## PARENTS

10 NAME OF FATHER Bartholomew Mullenix  
 11 BIRTHPLACE OF FATHER (State or country) Pa  
 12 MAIDEN NAME OF MOTHER Margarett Lynch  
 13 BIRTHPLACE OF MOTHER (State or country) Pa

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mary C. Jackson  
 (Address) Hagerstown Md

15 Filed 7/22, 1914 Henny Davis  
 REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7-21, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1914, to July 21, 1914,  
 that I last saw him alive on 7/21 4:30 PM, 1914

and that death occurred on the date stated above, at 7-300 m.

The CAUSE OF DEATH\* was as follows:

Endocarditis Chronic  
Cystitis  
 (Duration) 2 1/2 yrs. mos. ds.

Contributory ☒  
Secondary

(Duration) ..... yrs. mos. ds.  
 (Signed) Victor Swiller, M. D.  
7/22, 1914 (Address) Hagerstown

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. .... mos. .... ds. In the State ..... yrs. .... mos. .... ds.

Where was disease contracted,  
 If not at place of death?

Former or  
 usual residence

19 PLACE OF BURIAL OR REMOVAL Rose Hill Cemetery DATE OF BURIAL July 23, 1914

20 UNDERTAKER Watkins & Minnick ADDRESS Hagerstown Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

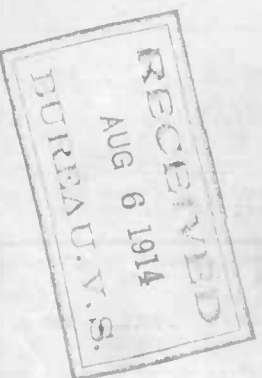
[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 10 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-ferential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## 1 PLACE OF DEATH

7161

County

Washington

Village or City

Near Smithsburg

(No.)

## 2 FULL NAME

Lydia Ann Myers

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 308

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female  
4 COLOR OR RACE White  
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH 6 24 1849  
(Month) (Day) (Year)

7 AGE 65 yrs. 1 mos. 7 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Home Wife  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Near Smithsburg

10 NAME OF FATHER Jacob Miner

11 BIRTHPLACE OF FATHER (State or country) Near Letersburg

12 MAIDEN NAME OF MOTHER Susan Caste

13 BIRTHPLACE OF MOTHER (State or country) Smithsburg Md

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant

Frederick Myers

(Address)

Letersburg Md

15

Filed

July 31, 1914

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July - 31, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July - 25 - 1914, to July - 31 - 1914, that I last saw her alive on July - 30 - 1914

and that death occurred on the date stated above, at 1:30 A.M.  
The CAUSE OF DEATH\* was as follows:

Bowel Obstruction

(Duration) yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Wishard, M. D.  
131 (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Letersburg Md July 28, 1914

## 20 UNDERTAKER

ADDRESS

Geo B. Hoover Smithsburg

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

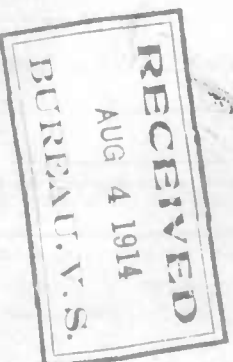
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc. *Carcin-*

*oma, Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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## PLACE OF DEATH

7162

County WashingtonSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistered No. 302Village or City Hagerstown (No. 344 S. Court St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## FULL NAME

Elias E. Palmer

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married  
(Write the word)

6 DATE OF BIRTH Nov 24, 1914  
(Month) (Day) (Year)

7 AGE 54 yrs. 8 mos. 7 ds. 11 LESS than 1 day, hrs. OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Wilmingon Md

10 NAME OF FATHER Samuel Palmer

11 BIRTHPLACE OF FATHER (State or country) Wilmingon Md

12 MAIDEN NAME OF MOTHER Susan Davis

13 BIRTHPLACE OF MOTHER (State or country) Wilmingon Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma J. Palmer344 (Address) S. Court St Hagerstown Md

15 Filed 7/11, 1914 Henry Davis  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 8, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1914, to July 8, 1914, that I last saw him alive on July 8, 1914.

and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH\* was as follows:

Chronic Endocarditis (Mitral and Aortic Insufficiency)(Duration) 6 yrs. 6 mos. 0 ds.Contributory (Secondary) Pulmonary Oedema(Duration) 1 yrs. 0 mos. 1 ds.(Signed) J. McWaggon, M. D.July 9, 1914 (Address) Hagerstown, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Bonifera Rd. Csm. DATE OF BURIAL July 11, 1914

20 UNDERTAKER S. K. Bowman ADDRESS Hagerstown Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestive," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **7163**  
County Washington

Village or City Clear Spring No. \_\_\_\_\_ St.; \_\_\_\_\_ Ward)

2 FULL NAME Julia May Peck

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 303

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single  
(Write the word)

6 DATE OF BIRTH Aug 12, 1918  
(Month) (Day) (Year)

7 AGE 0 yrs 11 mos 5 ds If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Clear Spring

PARENTS  
10 NAME OF FATHER Joseph G. Peck  
11 BIRTHPLACE OF FATHER (State or country) Fulton Co Pa  
12 MAIDEN NAME OF MOTHER Nora Soffacool  
13 BIRTHPLACE OF MOTHER (State or country) Wash. Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Peck  
(Address) Clear Spring Md.

15 Filed July 18, 1914 David S. Miller  
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 17<sup>th</sup>, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 16<sup>th</sup>, 1914 to July 17<sup>th</sup>, 1914  
that I last saw her alive on July 17<sup>th</sup>, 1914

and that death occurred on the date stated above, at 3 P.m.

The CAUSE OF DEATH\* was as follows:

Cholera Infantum

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Jonathan P. Perry, M. D.  
July 17<sup>th</sup>, 1914 (Address) Clear Spring

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Bleiss Valley Chapel DATE OF BURIAL July 18<sup>th</sup>, 1914

20 UNDERTAKER Franky Bros & Co ADDRESS Clear Spring

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

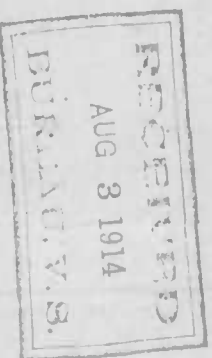
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Triema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH			STATE OF MARYLAND	
County <u>Washington</u>			CERTIFICATE OF DEATH	
Village or City <u>Keadysville, Md</u> (No. <u>79</u> )			Registration Dist. No. <u>346</u>	
2 FULL NAME <u>George W Poffenburg</u>			[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widower</u> (Write the word)		
6 DATE OF BIRTH <u>9 30 1854</u> (Month) (Day) (Year)				
7 AGE <u>59</u> yrs. <u>8</u> mos. <u>12</u> ds. If LESS than 1 day, hrs. OR min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Laborer</u>				
9 BIRTHPLACE (State or country) <u>Frank Co</u>				
PARENTS	10 NAME OF FATHER <u>Lawson Poffenburg</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Washington Co</u>			
	12 MAIDEN NAME OF MOTHER <u>Elizabeth Poffenburg</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Frank Co</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Bassie Criswell</u> (Address) <u>Philadelphia Pa</u>				
15 FILED <u>July 19 1914</u> <u>H. H. Sumner</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>July 17 1914</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY That I attended deceased from <u>July 17 1914</u> that I last saw him alive on <u>July 17 1914</u> and that death occurred on the date stated above, at <u>9 P. m.</u> The CAUSE OF DEATH* was as follows: <u>Arterio Sclerosis</u>				
Contributory <u>Arterio Sclerosis</u> (Duration) <u>Unknown</u> yrs. mos. ds. Secondary <u>Unknown</u> (Duration) <u>Unknown</u> yrs. mos. ds.				
(Signed) <u>H. H. Sumner</u> M. D. <u>July 18 1914</u> (Address) <u>Keadysville, Md.</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>          </u> yrs. <u>          </u> mos. <u>          </u> ds. In the State <u>          </u> yrs. <u>          </u> mos. <u>          </u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u>          </u>				
19 PLACE OF BURIAL OR REMOVAL <u>Boonsboro Md</u>			DATE OF BURIAL <u>July 20 1914</u>	
20 UNDERTAKER <u>C. L. Sumner &amp; Co</u>			ADDRESS <u>Keadysville Md</u>	

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

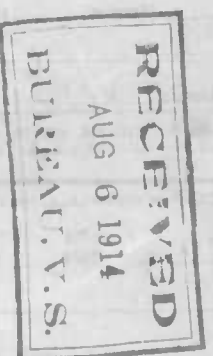
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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Lar-*

*ona*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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7165

## 1 PLACE OF DEATH

County WashingtonVillage or City Hagerstown (No. 317 Cannon St. 3rd Ward)2 FULL NAME InfantSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Jewish 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single  
(Write the word)

6 DATE OF BIRTH 7 28, 1914  
(Month) (Day) (Year)

7 AGE \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work \_\_\_\_\_

(b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

## 9 BIRTHPLACE

(State or country) Hagerstown Md

## PARENTS

10 NAME OF FATHER Isaac Pollock

## 11 BIRTHPLACE OF FATHER

(State or country) Odessa Russia12 MAIDEN NAME OF MOTHER Minnie Kuntelack

## 13 BIRTHPLACE OF MOTHER

(State or country) Polotsk Russia

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Pollock(Address) Hagerstown Md

## 15

Filed 7/28, 1914REGISTRAR Henry Davis

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 7 28, 1914

(Month)

(Day)

(Year)

## 17

I HEREBY CERTIFY, That I attended deceased from

July 28, 1914, to July 28, 1914.that I last saw him at home on \_\_\_\_\_, 1914.and that death occurred on the date stated above, at 2 A m.

The CAUSE OF DEATH\* was as follows:

Still Born  
Instrumental Delivery  
(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

## Contributory

Secondary \_\_\_\_\_

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) J. M. Campbell

M. D.

July 28, 1914 (Address) Hagerstown Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? \_\_\_\_\_

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Half wayDATE OF BURIAL 7/28, 191420 UNDERTAKER Benj. BerksonADDRESS Hagerstown

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PERIPERAL, septicæmia," "PERIPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on nomenclature of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificate.

**1 PLACE OF DEATH** 7166 ✓ (105)  
 County Washington

**STATE OF MARYLAND**  
**CERTIFICATE OF DEATH**

Registration Dist. No. 302

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Hagerstown (No. 73, Madison Ave., 2<sup>nd</sup> Ward)

**2 FULL NAME** John Leroy Ritzauer

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**PERSONAL AND STATISTICAL PARTICULARS**

**3 SEX** male **4 COLOR OR RACE** white **5 SINGLE, MARRIED, WIDOWED, OR DIVORCED** single (Write the word)

**6 DATE OF BIRTH** Oct 22<sup>nd</sup>, 1911 (Month) (Day) (Year)

**7 AGE** 2 yrs. 8 mos. 19 ds. **11 LESS than** 1 day.....hrs. OR.....min. ?

**8 OCCUPATION** (a) Trade, profession, or particular kind of work. None (b) General nature of industry, business, or establishment in which employed (or employer) "

**9 BIRTHPLACE** (State or country) Penn.

**PARENTS**

**10 NAME OF FATHER** John Ritzauer

**11 BIRTHPLACE OF FATHER** (State or country) Penn.

**12 MAIDEN NAME OF MOTHER** Maud Whitney.

**13 BIRTHPLACE OF MOTHER** (State or country) Penn.

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE** (Informant) John Ritzauer (Address) 73 Madison Ave

**15** Filed 7/13, 1914 Harry Davis REGISTRAR

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**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH** 7 11, 1914 (Month) (Day) (Year)

**17** 7/6, 1914 to 7/11, 1914 I HEREBY CERTIFY, That I attended deceased from that I last saw him alive on 7/10, 1914 and that death occurred on the date stated above, at 4 a. m. The CAUSE OF DEATH\* was as follows:

Discolitis (Duration) 6 yrs. 6 mos. 6 ds.

Contributory Secondary Spleen (Duration) 3 yrs. 3 mos. 3 ds.

(Signed) W. S. Lipp, M. D. 7/12, 1914 (Address) Hagerstown

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

**18 LENGTH OF RESIDENCE** (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death        yrs.        mos.        ds. In the State        yrs.        mos.        ds. Where was disease contracted, If not at place of death?        Former or usual residence       

**19 PLACE OF BURIAL OR REMOVAL** Rose Hill Cemetery **DATE OF BURIAL** 7/13, 1914

**20 UNDERTAKER** Edmundson Son **ADDRESS** Hagerstown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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7167

## 1 PLACE OF DEATH

County WashingtonSTATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 302Village or City Hagerstown (No. 216 Main Ave. St.; 2nd Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George W. Settle

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widower

6 DATE OF BIRTH June 20, 1889  
(Month) (Day) (Year)

7 AGE 75 yrs. - 19 mos. 19 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Cooper  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Gayton Settle

11 BIRTHPLACE OF FATHER (State or country) Virginia

12 MAIDEN NAME OF MOTHER No Record

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William H. Settle

(Address) Hagerstown Md

15 Filed 7/11, 1914 Henry Davis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 9, 1914  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 6, 1914, to July 9, 1914, that I last saw him alive on July 9, 1914

and that death occurred on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH\* was as follows:

Chronic Paralytic  
Exhaustion  
Unwieldy  
(Duration) many yrs. 19 mos. 19 ds.  
Contributory Unwieldy  
Secondary (Duration) 1 yrs. 19 mos. 19 ds.

(Signed) J. H. Waggoner, M. D.  
July 10, 1914 (Address) Hagerstown Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 19 mos. 19 ds. In the State 1 yrs. 19 mos. 19 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Reliance, Virginia DATE OF BURIAL July 12, 1914

20 UNDERTAKER A. K. Coffman ADDRESS Hagerstown Md



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

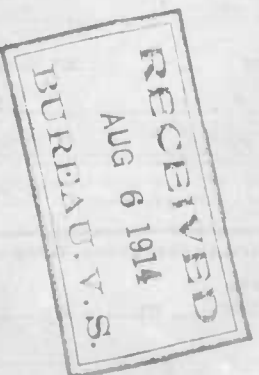
Approved by U. S. Census and American Public Health  
Association.<sup>1</sup>

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death.**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-renal," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Washington</u>		7168		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hagerstown</u>		(No. <u>Williamsport Pike</u> St.; <u>Ward</u> )		Registration Dist. No. <u>302</u>	
2 FULL NAME <u>James Raphael Shipley</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Infant</u> (Write the word)			
6 DATE OF BIRTH <u>June 18, 1913</u> (Month) (Day) (Year)					
7 AGE <u>1</u> yrs. <u>—</u> mos. <u>3</u> ds. <u>1</u> LESS than 1 day, <u>—</u> hrs. <u>—</u> min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>—</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>—</u>					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>Engene C. Shipley</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>Mary G. Lynch</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Mary A. Shipley</u> (Address) <u>Baltimore Md</u>					
15 Filed <u>7/31</u> , 191 <u>4</u> <u>Henry Davis</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>July 21</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, that I attended deceased from <u>July 21</u> , 191 <u>4</u> , to <u>July 21</u> , 191 <u>4</u> , that I last saw him alive on <u>July 21</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>11:30 A.M.</u> The CAUSE OF DEATH* was as follows: <u>Cholera Infantum</u>					
Contributory <u>Exhaustion</u> Secondary (Duration) yrs. <u>—</u> mos. <u>18 hrs.</u>					
(Signed) <u>John M. Dwyer</u> , M. D. <u>July 21</u> , 191 <u>4</u> . (Address) <u>Hagerstown</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, If not at place of death? <u>—</u> Former or usual residence <u>—</u>					
19 PLACE OF BURIAL OR REMOVAL <u>Baltimore Md</u> DATE OF BURIAL <u>July 23</u> , 191 <u>4</u>					
20 UNDERTAKER <u>A. K. Cryman</u> ADDRESS <u>Hagerstown</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac- cident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **7169**  
 County Washington  
 Village or City State line (No. 152)  
 2 FULL NAME Harry K Shuck  
 STATE OF MARYLAND  
 CERTIFICATE OF DEATH  
 Registration Dist. No. 302  
 St. \_\_\_\_\_ Ward \_\_\_\_\_  
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M 4 COLOR OR RACE W 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) \_\_\_\_\_

6 DATE OF BIRTH July 17, 1914  
 (Month) (Day) (Year)

7 AGE 0 yrs. 0 mos. 4 ds. If LESS than 1 day, \_\_\_\_\_ hrs. OR \_\_\_\_\_ min. ?

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work \_\_\_\_\_  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE (State or country) Washington Co. Md.

PARENTS

10 NAME OF FATHER Harry M. Shuck

11 BIRTHPLACE OF FATHER (State or country) Franklin Co Pa

12 MAIDEN NAME OF MOTHER Clara M. Martin

13 BIRTHPLACE OF MOTHER (State or country) Washington Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
 (Informant) Harry M. Shuck  
 (Address) State Line, Pa.

15 7/22 1914 Henry Davis  
 Filed \_\_\_\_\_ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 21, 1914  
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1914, to July 21st, 1914, that I last saw him alive on July 20th, 1914, and that death occurred on the date stated above, at 12 P m.  
 The CAUSE OF DEATH\* was as follows:  
Cerebral Hemorrhage from pressure on Head during Birth  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. 4 ds.

Contributory (Secondary) \_\_\_\_\_  
 (Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) D. C. Miller M. D.  
 191 \_\_\_\_\_ (Address) W. R. C. & W. R. C.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)  
 At place of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.  
 Where was disease contracted, if not at place of death? \_\_\_\_\_  
 Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL U B Cemetery DATE OF BURIAL July 23, 1914

20 UNDERTAKER A R Breunbaker ADDRESS State Line Pa

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative deathfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcinoma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Senile," etc.), "Dropsy," "Exhaustion," "Fart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.





WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exet statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			7170			STATE OF MARYLAND CERTIFICATE OF DEATH		
County <u>Wash Co.</u>			(79)			Registered No. <u>303</u>		
Village or City <u>Stuyette P.O.</u> (No. _____)			St.; _____			Ward _____		
2 FULL NAME <u>Mrs Mary Spracken</u>			[If death occurred in a hospital or institution, give its NAME instead of street and number.]					
PERSONAL AND STATISTICAL PARTICULARS								
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widow</u>						
6 DATE OF BIRTH <u>Dec - 29 - 1925</u> (Month) (Day) (Year)								
7 AGE <u>88</u> yrs. <u>6</u> mos. <u>10</u> ds. If LESS than 1 day, ____ hrs. OR ____ min. ?								
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House Keeper</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____								
9 BIRTHPLACE (State or country) <u>Greensboro, Frederick Co</u>								
PARENTS								
10 NAME OF FATHER <u>Jacob Hammer</u>								
11 BIRTHPLACE OF FATHER (State or country) <u>Germany</u>								
12 MAIDEN NAME OF MOTHER <u>Risella Eyer</u>								
13 BIRTHPLACE OF MOTHER (State or country) <u>Frederick Co</u>								
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs Risella Brown</u> (Address) <u>Bagentons R. F. D.</u>								
15 Filed <u>July 11</u> , 191 <u>4</u> <u>David D. Miller</u> REGISTRAR								
MEDICAL CERTIFICATE OF DEATH								
16 DATE OF DEATH <u>July 1</u> , 191 <u>4</u> (Month) (Day) (Year)								
17 I HEREBY CERTIFY, That I attended deceased from <u>2/2</u> , 191 <u>3</u> , to <u>2/2</u> , 191 <u>3</u> , that I last saw her alive on <u>2/2</u> , 191 <u>3</u> , and that death occurred on the date stated above, at <u>10 P.</u> m.								
The CAUSE OF DEATH* was as follows: <u>Endocarditis Chronic</u>								
(Duration) <u>9</u> yrs. ____ mos. ____ ds.								
Contributory (Secondary) _____								
(Signed) <u>John Miller</u> , M. D. <u>July 10</u> , 191 <u>4</u> (Address) <u>Mag. Rd</u>								
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.								
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? _____ Former or usual residence _____								
19 PLACE OF BURIAL OR REMOVAL <u>Williamstown Md</u>						DATE OF BURIAL <u>July 13<sup>th</sup></u> , 191 <u>4</u>		
20 UNDERTAKER <u>J. M. Miller</u>						ADDRESS <u>Wm. J. Miller</u>		

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

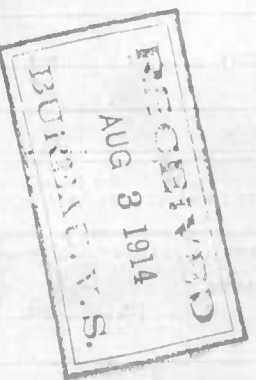
Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Cooling*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the **MISUSE CAUSING DEATH** (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Junction," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH

7171

County

Washington

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No.

302

Village or City

Hagerstown

(No.)

Belune

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John Suter

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word)

6 DATE OF BIRTH

— 10 — 11, 1857  
(Month) (Day) (Year)

7 AGE

57 yrs — mos — ds. OR LESS than 1 day, — hrs. — min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Don't know

## PARENTS

10 NAME OF FATHER

" "

11 BIRTHPLACE OF FATHER (State or country)

" "

12 MAIDEN NAME OF MOTHER

" "

13 BIRTHPLACE OF MOTHER (State or country)

" "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas. S. Suter

(Address)

Hagerstown Md.

15

Filed

7/2

1914

Henry Davis

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

July 2, 1914  
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

April 1, 1914, to July 2, 1914.

that I last saw him alive on June 29, 1914.

and that death occurred on the date stated above, at 7 a. m.

The CAUSE OF DEATH\* was as follows:

Pyelonephritis + cystitis

(Duration) — yrs. 3 mos. — ds.

Contributory  
Secondary

Paralysis

(Duration) 26 yrs. — mos. — ds.

(Signed)

F. D. Hoffman

, M. D.

July 2, 1914 (Address) Hagerstown Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Belune

DATE OF BURIAL

7/3, 1914

20 UNDERTAKER

Harker Munnich Hager, Md.

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

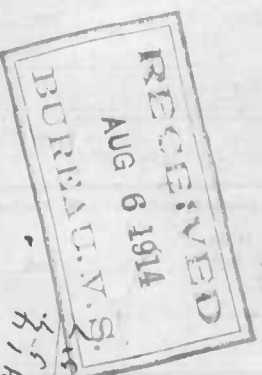
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thema," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH  
County Washington

7172

(28)

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 306

Village or City Pleasant Valley (No. 5)

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Halford. C. Toms

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OF RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH 7 10 1879  
(Month) (Day) (Year)

7 AGE 42 yrs. — mos. 8 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Pleasant Valley

10 NAME OF FATHER Soloman Toms

11 BIRTHPLACE OF FATHER (State or country) Pleasant Valley

12 MAIDEN NAME OF MOTHER Sarah Smith

13 BIRTHPLACE OF MOTHER (State or country) Pleasant Valley

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant Wm. Clayton Toms

(Address) Smithsburg Md

15 Filed July 17, 1914 J. W. Ferguson REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH July 18th, 1914  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_.

that I last saw him alive on or about March, 1914.

and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis

Caval  
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Joseph Protzman, M. D.  
July 8, 1914 (Address) Smithsburg, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, It not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Pleasant Valley DATE OF BURIAL July 20, 1914

20 UNDERTAKER Geo. B. Hoover ADDRESS Smithsburg

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.



# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

*oma*, *Sarcoma*, etc., of \_\_\_\_\_ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Westphals," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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JUL 31 1914

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH. <b>7173</b> <i>Washington</i>		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <i>Washington</i>		Registration Dist. No. <b>300</b>	
Village or City <i>Sharpsburg</i>		St. _____ Ward _____	
2 FULL NAME <i>John T William Vickers</i>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <i>male</i>	4 COLOR OR RACE <i>white</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>married</i> (Write the word)	
6 DATE OF BIRTH <i>Feb. 26, 1887</i> (Month) (Day) (Year)			
7 AGE <i>27 yrs 4 mos 8 ds.</i>		If LESS than 1 day, _____ hrs. OR _____ min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>Carpenter</i> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <i>West. Va.</i>			
PARENTS	10 NAME OF FATHER <i>John W. Vickers</i>		
	11 BIRTHPLACE OF FATHER (State or country) <i>Maryland</i>		
	12 MAIDEN NAME OF MOTHER <i>Barbara C. Hammond</i>		
	13 BIRTHPLACE OF MOTHER (State or country) <i>Maryland</i>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>John W. Vickers</i> (Address) <i>Bakersville Md</i>			
15 Filed <i>7/5/</i> , 1914 <i>Chas. N. Hoffmaster</i> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <i>7</i> <i>4</i> , 191 <i>4</i> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <i>May 25</i> , 191 <i>4</i> , to <i>July 4</i> , 191 <i>4</i> , that I last saw him alive on <i>July 3</i> , 191 <i>4</i> , and that death occurred on the date stated above, at <i>About 7 P.m.</i> The CAUSE OF DEATH* was as follows: <i>Typhoid Fever</i>			
(Duration) _____ yrs. _____ mos. _____ ds.			
Contributory _____ Secondary _____			
(Duration) _____ yrs. _____ mos. _____ ds.			
(Signed) <i>S. Hamill Gardner</i> , M. D. <i>July 5</i> , 191 <i>4</i> (Address) <i>Sharpsburg Md</i>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <i>Sharpsburg Md</i>		DATE OF BURIAL <i>July 6</i> , 191 <i>4</i>	
20 UNDERTAKER <i>Albert Lee Sharpsburg Md</i>		ADDRESS	
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.			

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Washington</u>		7174 (187)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Sharpsburg</u>		No. <u>9</u>		Registration Dist. No. <u>300</u>	
2 FULL NAME <u>John Henry Wilhelm</u>				[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widowed</u>			
6 DATE OF BIRTH <u>July 3, 1833</u> (Month) (Day) (Year)					
7 AGE <u>81</u> yrs. — mos. — ds. <u>8</u> If LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Retired</u> (b) General nature of Industry, business, or establishment in which employed (or employer) <u>Road Supervisor</u>					
9 BIRTHPLACE (State or country) <u>Virginia</u>					
PARENTS	10 NAME OF FATHER <u>David Wilhelm</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>U. S.</u>				
	12 MAIDEN NAME OF MOTHER <u>Annie Powers</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>U. S.</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Eugene Wilhelm</u> (Address) <u>Sharpsburg Md</u>					
15 Filed <u>7/13/</u> 1914 <u>Chas. N. Hoffmaster</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>7</u> <u>11</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased <del>2000</del> <u>At different</u> 191 <u>4</u> times for <u>24</u> years <u>101</u> that I last saw him alive <u>about 3 or 4</u> who <u>age 101</u> and that death occurred on the date stated above, at <u>5 P. m.</u> The CAUSE OF DEATH* was as follows: <u>General debility - Death was very sudden, possibly heart failure from acute indigestion</u> (Duration) _____ yrs. _____ mos. _____ ds.					
Contributory _____ Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>D. Howell Gardner</u> , M. D. <u>7/12</u> , 191 <u>4</u> (Address) <u>Sharpsburg Md</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Sharpsburg Md</u> DATE OF BURIAL <u>July 14</u> , 191 <u>4</u>					
20 UNDERTAKER <u>Albert Lee Sharpsburg Md.</u> ADDRESS _____					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indelinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "As-theia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

AUG 5 1914

BUREAU, U. S.



7175

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 301[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]1 PLACE OF DEATH  
County WashingtonVillage or City Halfway (No. 185) St.          Ward         2 FULL NAME Annie Elizabeth Williams

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow6 DATE OF BIRTH Jan. 30, 1829  
(Month) (Day) (Year)7 AGE 85 yrs. 5 mos. 21 ds. OR LESS than 1 day,          hrs.          min. ?8 OCCUPATION  
(a) Trade, profession, or particular kind of work No work at all  
(b) General nature of industry, business, or establishment in which employed (or employer) incapacitated9 BIRTHPLACE (State or country) Clearspring Md10 NAME OF FATHER Unknown11 BIRTHPLACE OF FATHER (State or country) Unknown12 MAIDEN NAME OF MOTHER Matilda Sims13 BIRTHPLACE OF MOTHER (State or country) Clearspring Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Kate Hipkins  
(Address) Halfway, Md.15 Filed July 21, 1914 by C. E. Rickard  
LOCAL REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 20, 1914  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from July 17, 1914, to July 20, 1914,  
that I last saw him alive on July 18, 1914and that death occurred on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH\* was as follows:

Fracture of hip due to fall from window.  
F.V.B.Contributory Exhaustion (Duration) 1 yrs. 4 mos. 4 ds.Secondary                      (Duration) X yrs. X mos. 4 ds.Signed J. M. Wagaman, M. D.  
July 20, 1914 (Address) Halfway, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death          yrs.          mos.          ds. In the State          yrs.          mos.          ds.Where was disease contracted, If not at place of death?         Former or usual residence         19 PLACE OF BURIAL OR REMOVAL Clearspring DATE OF BURIAL July 22, 191420 UNDERTAKER Grantz Brothers ADDRESS Clearspring

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting Form No. 1.

MARGIN RESERVED FOR BINDING

V. S. No. 1.

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*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Jaundition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Washington</u>		7176	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Rogersstown</u> (No. <u>444</u> <u>W. Franklin</u> St.; <u>5<sup>th</sup></u> Ward)		Registration Dist. No. <u>302</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME <u>Helen Louise Young</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>		
6 DATE OF BIRTH <u>July</u> <u>7</u> , 191 <u>4</u> (Month) (Day) (Year)				
7 AGE — yrs. — mos. <u>7</u> ds. <u>7</u> If LESS than 1 day, .... hrs. OR .... min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Child</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>C</u>				
9 BIRTHPLACE (State or country) <u>Maryland</u>				
PARENTS	10 NAME OF FATHER <u>Herbert Highsmith</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>			
	12 MAIDEN NAME OF MOTHER <u>Bertha M. Young</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Henry Beck Young</u> (Address) <u>Rogersstown, Md.</u>				
15 Filed <u>7-15</u> , 191 <u>4</u> <u>Henry Davis</u> , REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>July</u> <u>15</u> , 191 <u>4</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>July 7</u> , 191 <u>4</u> , to <u>July 15</u> , 191 <u>4</u> , that I last saw her alive on <u>July 15</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>9:10</u> a.m. The CAUSE OF DEATH* was as follows:				
<u>Unilateral Hemorrhage</u> <u>after separation of uterus</u> Duration) <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds.				
Contributory <u>8</u> Secondary				
(Signed) <u>Henry Beck Young</u> , M. D. <u>July</u> , 191 <u>4</u> (Address) <u>Hagerstown, Md.</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>7</u> yrs. <u>1</u> mos. <u>1</u> ds. In the State <u>7</u> yrs. <u>1</u> mos. <u>1</u> ds. Where was disease contracted, If not at place of death? Former or usual residence.				
19 PLACE OF BURIAL OR REMOVAL <u>Rogersstown, Md.</u> DATE OF BURIAL <u>July 15</u> , 191 <u>4</u>				
20 UNDERTAKER <u>H. C. Lysman</u> ADDRESS <u>Rogersstown, Md.</u>				

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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